

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 010984	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/17/2013
NAME OF PROVIDER OR SUPPLIER ALLIED PHYSICIANS SURGERY CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 53990 CARMICHAEL DR STE 100 SOUTH BEND, IN 46635		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for a standard licensure survey.</p> <p>Facility Number: 010984</p> <p>Survey Date: 4/16 & 17/2013</p> <p>Surveyors: ReBecca Lair, LCSW Medical Surveyor</p> <p>Deborah Franco, RN Public Health Nurse Surveyor</p> <p>Allied Physicians Surgery Center is in compliance with 410 IAC 15.2, Ambulatory Surgery Center Licensure Rules.</p> <p>QA: cloughlin 04/22/13</p>	S 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

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If continuation sheet 1 of 1